that lack both the motivation and the skills to be fundholders is a high risk strategy. The parliamentary Public Accounts Committee has watched closely the development of the scheme, and failures in financial control would intensify parliamentary scrutiny.

To avoid this danger, ministers have just published a framework for clarifying and streamlining fundholders' accountability.[5] This is based on a consultation document issued last year and deals primarily with fundholders' management accountability and their accountability to patients and the public. Although the framework is a welcome recognition of the need to balance greater freedom for general practitioners with increased accountability, how effectively it will work in practice remains to be seen. Not least, health authorities operating under tightly constrained spending on management may find it difficult to do more than assess fundholders' performance on a broad brush and mechanistic basis.

The hand of the Treasury is discernible in the encouragement being given to fundholding. Given the fact that spending on drugs in general practice is one of the biggest sectors of NHS expenditure that is not cash limited, the fundholders' apparent ability to control pharmaceutical costs is understandably attractive to the government. Yet some health authorities—for example, in Nottingham—claim to have controlled prescribing budgets in non-fundholding practices more successfully than in fundholding practices. Again, this evidence underlines the need for better data so that the differing claims can be evaluated.

These points are not arguments against the principle of fundholding. On this question the jury is still out.[2] Nor do they undermine the principle of the NHS being led by primary care, which has commanded widespread support. But different models of purchasing should be tolerated and encouraged. Probably no single approach will apply in all circumstances, as experience so far shows. This is as relevant to the Labour party as to the government, particularly at a time when the opposition is hammering out its policy on the NHS.

But perhaps the most important lesson for all politicians is the need to base policies on evidence. The absence of good evaluative evidence on different approaches to commissioning is a serious stumbling block. Policymakers must take stock of what is known, initiate research to fill in the gaps, and let events take their course without presuming that one model of commissioning is superior to others. One of the most exciting features of the NHS reforms is the way in which they have enabled change to develop from the bottom up. It would be a tragedy if this scope for innovation were curtailed by a return to the old style of command and control management and a fruitless search for the right answer.

CHRIS HAM
Director

JONATHAN SHAPIRO
Senior fellow

Health Services Management Centre,
University of Birmingham,
Birmingham B15 2RT

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Commissioning complementary medicine

Researchers need to concentrate on showing that these treatments work

The opportunities presented to commissioning health authorities to decide what health care to purchase for local people has also provided an opportunity to rethink old prejudices. The old prejudices against complementary medicine are being rethought for several reasons. Firstly, many commissioning authorities and fundholding general practitioners are either commissioning or providing complementary medicine as part of routine contracting.[1] Financially, this is marginal activity, costing typically less than £20 000 a year out of an average authority budget of £200m. Also some complementary medicines, such as acupuncture and homoeopathy, have been part of normal NHS activity for many years and this has blurred the margins between conventional and complementary medicine. Secondly, the medical profession has relaxed its attitude toward complementary medicine over the past decade.[2] Thirdly, both main political parties support the development of complementary medicine as an issue of choice for patients and have supported the accreditation, registration, and training of chiropractors and osteopaths. Finally, there is widespread anecdotal evidence of the incremental, not necessarily commissioned, introduction of some complementary therapies, such as reflexology and aromatherapy, into clinical practice.

Commissioners therefore have a dilemma. If they actively commission complementary medicine what do they need to know to make informed decisions? The drive is to commission only those health care interventions that are clinically effective, and there is a wide acceptance that such an argument should also be applied to complementary medicine. The burden of such proof should be no greater, or less, than for mainstream medicine.

The hierarchy of evidence of effectiveness recognises randomised controlled trials as the gold standard. However, most interventions, both conventional and complementary, have never been subjected to good quality randomised controlled trials. Moreover, such trials may not be the best way of assessing whether complementary medicines are effective. The reductionist approach of the randomised controlled trial may fail to allow for the holistic effect that is central to the philosophy of most complementary therapies.[3] Furthermore, the beneficial effects are often so obvious, the side effects so rare and mild, and the duration of effect so variable after even a single exposure that perhaps observational studies may be enough to prove benefit.[4] If not, then randomised controlled trials that compare whole treatments, or packages of care, rather than individual treatments may be a better approach. This would allow inclusion of the things that matter to patients rather than just those that matter to the investigators.[3]

One problem is the lack of a wide ranging literature review of the evidence for effectiveness of complementary medicines. Such a review is, however, being undertaken by the Nuffield Institute for Health and is due for publication this year. Commissioners also need information about accreditation of practitioners and about the development and evaluation of centres for complementary medicine in places such as

Southampton, Liverpool, Lewisham, and Marylebone.[5] The National Association of Health Authorities and Trusts has agreed that some form of exchange of information for providers and commissioners is desirable, and this process is currently being developed.

West Yorkshire Health Authority has already committed itself to developing a range of complementary therapies based in primary care.[5] This experimental approach needs to continue if commissioners are to think laterally about health care while struggling with all their other priorities. The planned enhancement of commissioning based in primary care will almost certainly increase the opportunities for complementary medicine as a real alternative to some secondary care services—for example, for the management of stress and chronic back pain. The challenge for commissioners is to substitute complementary medicine for conventional treatments rather than simply add to the range of treatments and costs.

Complementary medicine in its broadest sense also needs to try to explain why it works. The lack of such explanations are a major concern for most conventionally trained doctors, who struggle with concepts such as the power of the placebo effect and the role of Avogadro's number and homoeopathic dilutions. That may be hard; in the meantime, the immediate issue for research in complementary medicine is not why things work but to show that they do.

IAIN SMITH
Senior lecturer in health services research

Nuffield Institute for Health,
Leeds LS2 9PL

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Tackling inequalities in health

Great need for evidence based interventions

What can be done about socioeconomic inequalities in health? A report by the King's Fund contains an impressive agenda for action.[1] The objective of the report was "to outline a number of practical and affordable ways in which the situation could be substantially improved, if the political will existed to recognise that tackling inequalities in health is a fundamental requirement of social justice for all citizens."

The report identifies four areas for intervention: the physical environment, social and economic factors, barriers to adopting a healthier personal lifestyle, and access to appropriate and effective health and social services. For each area one factor has been selected to illustrate possible policy initiatives: housing, income maintenance, smoking, and access to health care. The initiatives range from the development of innovative health education programmes to investments in social housing (to be financed by, among other things, the abolition of tax relief on mortgages) and from ensuring an equitable allocation of NHS resources to changes in the tax system (for example, an increase in the highest rate of income tax).

This brief summary of the report cannot do justice to the richness of its ideas. This richness makes the report a welcome complement to a lucid but much thinner discussion paper by the World Health Organisation that was published a few years ago.[2] It also reinforces a recent paper on inequalities in health issued by the BMA, which concluded that "a total rather than service-orientated approach is needed across all sectors of government." The BMA's paper identified a wider range of policy areas that should be involved in this strategy: economic policy ("particularly taxation policy"), provision of welfare benefits, education and child care, unemployment, environment, housing, transport, and leisure.[3]

The broad and varied approach advocated in these reports certainly fits the scale and nature of the problem: inequalities in health are a widespread phenomenon, resulting from a complex interplay of many different factors; substantial reductions in them are unlikely unless some of their root causes, such as inequality of income, are addressed. On the other hand, the wide range of policy options also shows uncertainty about which measures are necessary and likely to be effective. Much more helpful would be a more parsimonious package that targeted several specified key areas of concern within the larger domain of socioeconomic inequalities in health, focused on the known causes of these inequalities, and used interventions of established efficacy in reducing these inequalities. Unfortunately, current knowledge allows only the first two of these requirements to be (partially) met.

This can be shown for one key area of concern: the widening of the difference in mortality between rich and poor people. Over the past three or four decades there has been consistent evidence of increasing socioeconomic inequalities in mortality, both in Britain and in several other industrialised countries.[4-9] There are two competing explanations. One emphasises the possible role of increasing inequalities in income and one focuses on the possible contribution of changes in the distribution of behavioural risk factors. For Britain, evidence exists that the increases in the size of socioeconomic inequalities in mortality are related to increases in the size of inequalities in income,[10,11] and this relation also emerges from international comparisons at one point in time.[12] The competing explanation for the widening difference in mortality focuses on changes in the social distribution of behavioural risk factors. One of the main contributors to the widening difference in mortality is ischaemic heart disease, which over the past 40 years has changed from being an upper class to a lower class disease. These changes are mirrored by comparable changes in risk factors for ischaemic heart disease, such as smoking and obesity.[13]

Evidence thus suggests that both reducing inequalities in income and reducing the social gradient in smoking and other behavioural risk factors could result in a slowing down or perhaps even reversal of the widening difference in mortality. Unfortunately, however, this is not enough. Both types of intervention have a price, in political, economic, or simply monetary terms. To justify the costs and to enable policymakers to choose rationally from the available policy options, quantitative information is needed on the effectiveness of these interventions. Public health researchers and practitioners frequently criticise those practising clinical medicine for the lack of evidence of the effectiveness of medical interventions.[14] They argue, legitimately, that knowledge of the aetiology and pathophysiology of a disease is not enough to justify treatments that seemingly address these factors. What